DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G715	B. WING		09/02/2011
				ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIER			RK LANE	
CHRISTO	OLE INC			/ILLE, IN47448	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	IX (EACH CORRECTIVE ACTION SHOULD BE COM-	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0000					
W0104	the investigation of completed on July 11 deficiencies were cited Dates of Survey: Sep Facility number: 0044 Provider Number: 15 AIM Number: 20048: Surveyor: Steven Schaccordance with 431 The governing boo policy, budget, and the facility. Based on observation	otember 1 and 2, 2011. 000 6G715 1990 nwing, Medical Surveyor III so reflect state findings in	W0000 W0104	W 104Christole is committed supporting a governing body	07/30/2011
	body failed to exerce facility by failing to bedroom wall was refindings include: An observation was on 9/1/11 from 2:39 a 3 inch by 4 inch he bedroom wall above. An interview with E conducted on 9/1/11 the hole had been proposed the indicated Admin completed a mainter on 9/1/11 at 2:58 Pt.	ise operating direction over the ensure a hole in client C's epaired timely. conducted at the group home PM to 4:01 PM. At 2:51 PM, ole was observed in client C's		supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. The Maintenance Supervisor will ensure that the following area is repaired: A 3x4 inch hole in client C's bedroom wall. The repairs will be completed by September 30, 2011. Documentation of repair will be available at the Central office. The Program Director (PD) will train QDDP's and CLM's, and ACLM's on submitting maintenance requests. The Parklane QDDP or CLM will provide training on submitting Maintenance requests to group	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

004000

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G715	B. WING			09/02/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RK LANE		
CHRISTO	OLE INC				ILLE, IN47448		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ïΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		vas no maintenance request to			home staff. Both trainings wil		
repair the hole in client		ent C's wall.			completed by September 30,	1	
		C //1			2011. Copies of the training signature sheets will be avail	ablo	
		AS #1 was conducted on 9/1/11			at the Central office.	abie	
		indicated he did not complete hole in client C's bedroom			at the Gential office.		
	wall.	note in chefit C's bedroom					
	waii.						
	This deficiency was c	ited on 7/11/11. The facility					
		systemic plan of correction to					
	prevent recurrence.						
	1.1-3-1(a)		1				
W0149		evelop and implement					
		d procedures that prohibit					
		lect or abuse of the client.	1		W/440Christala is dedicated i	_	00/20/2011
		iew and interview for 4 of 6	I W	0149	W149Christole is dedicated i	n	09/30/2011
		group home (A, B, E and F),			maintaining a policy and environment that prohibits the	_	
		d to implement its policies and neglect of the			mistreatment, neglect, or abu		
	clients.	nt abuse and neglect of the			of the individual's served. Tra		
	chents.				on the prevention of abuse a	-	
	Findings include:				neglect has been added to the		
	i mamga merade.				New Employee Orientation.		
	A review of the facil	lity's incident/investigative			Quality Improvement Directo	r	
		ed on 9/1/11 at 1:01 PM.			(QID) will revise the Abuse a	nd	
	•	PM, client A pinched client F			Neglect Training Module to		
		vestigative report indicated			include specific training on st		
		on client F's neck. The facility			monitoring peer interaction a	nd	
	substantiated abuse				proximity. The QID will train		
	abuse/harm/injury.				QDDP's, CLM's, ACLM's and		
	-On 8/21/11 at 4:30	PM, client B hit a peer (the			Program Directors (PD) on the		
	report did not indica	te who) "lightly" on the arm			revision by September 30, 20 The Program Director (PD) w		
	and on the back of h	er head.			train Parklane group home st		
		PM, client A bit client B on			on the revision by Septembe		
	-	red mark. The facility			2011. A copy of the Abuse ar		
		without intent to cause harm.			Neglect Training Module revi		
		PM, staff #7 asked staff #2			and copies of both training		
		d been checked. Staff #2,			signature sheets will be avail	able	
	_	7 and #8, went into client E's			at the Central office.		
	room to check on hi	m. Staff #2 came back out of					

004000

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	(X2) MULTIPLE A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011
NAME OF I	PROVIDER OR SUPPLIEF	2	523 F	ET ADDRESS, CITY, STATE, ZIP (PARK LANE HVILLE, IN47448	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Staff #7 went into c and client E had bee feces. Staff #7 indiof urine. Staff #7 redried. Staff #7 redried. Staff #7 redried. Staff #7 redried. Staff #7 indibe negligent. Staff staff #2 to be negliginvestigative report Qualified Mental Re(QMRP) was conduindicated in her statincident on 7/21/11 not report the incide indicated the follow about it." The investing the QMRP's statemereport neglect. A review of the facing Report Process, date 9/1/11 at 2:17 PM. following, "People subjected to abuse to limited to, facility selected to a following individuals." The pindividual who has adult is a victim of report A person we child or adult is a victim of report A person we child or adult is a victim of report to be followithin 24 hours." The pindividual of staff to pincessary to avoid pharm."	indicated client E was fine. lient E's room 2 minutes later en incontinent of urine and cated client E's room smelled exported the feces was stuck and cated she considered staff #2 to #8 indicated she considered gent in his duties. The indicated an interview with the etardation Professional lected on 7/26/11. The QMRP ement she was informed of the The QMRP indicated she did ent to anyone. Her statement ring, "I wasn't sure how to go stigative report did not address ent that she was not sure how to lity's Investigative Incident ed 8/29/11, was conducted on The policy indicated the receiving services must not be oy anyone, including, but not taff, peers, consultants or members, friends or other olicy indicated, "Any reason to believe that a child or abuse or neglect must make a who has reason to believe that a ctim of abuse or neglect must all an Administrator with an lowed up with a written report the policy defined neglect as, rovide goods or services ohysical or psychological				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED
		15G715	B. WING		09/02/2011
NAME OF	PROVIDER OR SUPPLIEI	 		ADDRESS, CITY, STATE, ZIP CODE	.1
TWINE OF	I KO VIDEK OK SOI I EIEI		523 PAI	RK LANE	
CHRIST	OLE INC		NASHV	'ILLE, IN47448	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	PM. The DRS indi abuse and neglect o	cated the facility prohibits f the clients.			
		s cited on 7/11/11. The facility a systemic plan of correction ce.			
W0153	mistreatment, neg injuries of unknow immediately to the officials in accordadical established proces assed on record revincident/investigative clients B and E, the fadministrator was im BDDS (Bureau of De Services) was notified 24 hours, in accordadical Findings include: A review of the facility was conducted on 9/-On 8/21/11 at 4:30 for 8/23/11), client B hith who) "lightly" on the There was no BDDS hith. -On 7/20/11 at 1:00 for and administrative staff #7 asked staff #2, a into client E's room to back out of client E's fine. Staff #7 went in and client E had bee Staff #7 indicated client E fad bee Staff #7 indicated she con Staff #8 indicated she	iew and interview for 2 of 13 are ports reviewed afffecting facility failed to ensure the imediately notified of neglect and evelopmental Disabilities and of reportable incidents within nace with state law. By's incident/investigative reports 1/11 at 1:01 PM. PM (reported to BDDS on a peer (the report did not indicate arm and on the back of her head. The report for the person who was 1/25 and #8 if client E had been according to staff #7 and #8, went to check on him. Staff #2 came aroom and indicated client E was not client E's room 2 minutes later in incontinent of urine and feces. The reces was stuck and dried. Staff sidered staff #2 to be negligent. The reces was staff #2 to be reconsidered staff #2 to be	W0153	W 153 Christole is committed to supp a governing body that exercise general policy, budget and ope direction over the facility to op in substantial compliance with and Federal regulatory requirer The Quality Improvement Dire (QID) will create a BDDS Reportable acknowledgement The group home staff will be required to sign off on form da ensure all incidents have been reported. The form will need to completed each shift to ensure awareness of reporting of the E Reportable items. The QID will QDDP's, CLM's, ACLM's, and Program Directors (PD) on the the form by September 30, 2011 Program Director (PD) or QDI will train the Parklane group he staff on the acknowledgement form and the september 30, 2011. A copy the acknowledgement form and	s rating perate State ments. State ments. State form.
	staff #7 asked staff #2, a into client E's room to back out of client E's fine. Staff #7 went in and client E had bee Staff #7 indicated client #7 indicated she con	22 and #8 if client E had been ccording to staff #7 and #8, went to check on him. Staff #2 came room and indicated client E was not client E's room 2 minutes later in incontinent of urine and feces. ent E's room smelled of urine. feces was stuck and dried. Staff sidered staff #2 to be negligent.		Reportable items. The QID will QDDP's, CLM's, ACLM's, and Program Directors (PD) on the the form by September 30, 201 Program Director (PD) or QDI will train the Parklane group he staff on the acknowledgement	Il train d vuse of 11. The DP ome form y of d both

An interview with the Director of Residential Services

available at the Central office.

004000

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G715 09/02/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 523 PARK LANE CHRISTOLE INC. NASHVILLE, IN47448 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (DRS) was conducted on 9/1/11 at 2:12 PM. The DRS indicated the facility should report to BDDS within 24 hours. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 1.1-3-1(b)(5) 1.1-3-2(a) W0154 The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 13 W 154 W0154 09/30/2011 incident/investigative reports reviewed affecting client Christole is committed to supporting B, the facility failed to ensure a thorough investigation a governing body that exercises was conducted into abuse/neglect. general policy, budget and operating direction over the facility to operate Findings include: in substantial compliance with State A review of the facility's incident/investigative reports and Federal regulatory requirements. was conducted on 9/1/11 at 1:01 PM. The Quality Improvement Director (QID) will create a BDDS On 8/21/11 at 4:30 PM, client B hit a peer (the report Reportable acknowledgement form. did not indicate who) "lightly" on the arm and on the back of her head. There was no investigation The group home staff will be presented during the survey for review. An email, required to sign off on form daily to reviewed on 9/2/11 at 11:37 AM, from the Director of ensure all incidents have been Quality Improvement, dated 9/2/11 at 11:37 AM, reported. This will include indicated an investigation was not conducted for this immediately reporting any incidents incident. An email reviewed on 9/2/11 at 12:29 PM from the Director of Quality Improvement, dated of suspected abuse and neglect. The 9/2/11 at 12:29 PM, indicated an investigation should QID will train QDDP's, CLM's, have been conducted. ACLM's and PD's on the BDDS Reportable acknowledgement form. This deficiency was cited on 7/11/11. The facility This training will be completed by failed to implement a systemic plan of correction to September 30, 2011. The PD or prevent recurrence. QDDP will train the Parklane group 1.1-3-2(a) home staff on the BDDS acknowledgement form by September 30, 2011. A copy of the form and both training signature sheets will be available at the Central office.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C2H712

Facility ID: 004000

If continuation sheet

Page 5 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	I		00	COMPL	ETED
		15G715	A. BUII			09/02/2	011
		100710	B. WIN			00/02/2	011
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVI WILL OF T	ROVIDER OR SOLI EIER			523 PAI	RK LANE		
CHRISTO	DLE INC			NASHV	ILLE, IN47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	·F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
W0157	If the alleged viola corrective action n	tion is verified, appropriate nust be taken.					
	Based on record revie	ew and interview for 1 of 13	1 337	0157	W 157	•	09/30/2011
	incident/investigative	reports reviewed affecting client	"	0137	Christole is committed to suppo	rting	07/30/2011
	E, the facility failed to	ensure appropriate corrective			a governing body that exercises	-	
	action was taken.				general policy, budget and oper		
					direction over the facility to ope	-	
	Findings include:				in substantial compliance with S		
	A review of the facility	s incident/investigative reports			_		
	was conducted on 9/	<u> </u>			and Federal regulatory requirem		
					Christole has implemented Clie		
		M, staff #7 asked staff #2 and #8			Assignment sheets to ensure sta	II	
		hecked. Staff #2, according to			accountability to Individual	1.1	
	,	into client E's room to check on ack out of client E's room and			assignments. This process also l		
		s fine. Staff #7 went into client			staff accountable for appropriate		
		ater and client E had been			of assigned individuals. Trainin	-	
		nd feces. Staff #7 indicated			the client assignments process f		
	client E's room smelle	ed of urine. Staff #7 reported the			PD's, QDDP's, CLM's and ACI	LM's	
		dried. Staff #7 indicated she			was completed on August 24, 20	011.	
		be negligent. Staff #8 indicated			Training for Parklane group hor	ne	
		#2 to be negligent in his duties. nary action taken with staff #2.			staff was completed on July 6 a	nd	
	mere was no discipil	mary action taken with stall #2.			July 28, 2011. Copies of both		
	The investigative pac	ket contained two faxed			training signature sheets will be		
		cking Sheets, fax dated on			available at the Central Office.	Γhis	
		nd 1:44 PM. The report did not			process also allows Christole		
		ion to address the issue.			Administrative staff to monitor	for	
		I on her report, dated 7/20/11, ‡2] was asked to check on [client			any neglectful behavior and pro	vide	
		d changed since it was an hour			corrective action as appropriate.		
	•	in and came back out quickly,					
		went in about two minutes later					
		I checked [client E] and his bed					
		ad dried feces in his pull-up.					
		check on me to see why I had essed this as well. She is the					
		e soaked bed clothes while I had					
	•	es and changed [client E]. We					
		ent accident because the entire					
		the feces were (sic) dried all					
	around the sacral (sid	•					
		I on her report, dated 7/20/11,					
		#2] was asked if [client E] had aid he would check on [client E].					
		back out quickly and stated that					
		7] went in about 2 minutes later					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE COMP	
		15G715	B. WING		- 09/02/2	2011
NAME OF F	PROVIDER OR SUPPLIER		523 PA	ADDRESS, CITY, STATE, ZIP CO RK LANE /ILLE, IN47448	DE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		OULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W0210	check on [staff #8] ar #8] was the one to check on the control of the while [staff #7] cleans [staff #7 and #8] kneed because the bed was all around sacral (sic). An interview with the Services (DRS) on some indicated the investion addressed corrective with staff #2. 1.1-3-2(a) Within 30 days after interdisciplinary the assessments or resupplement the producted prior to Based on observation for 6 of 6 clients live C, D, E and F), the sclients' abilities to reassessed. Findings include: On 9/1/11 at 2:58 Pl Maintenance/Repair conducted. A form, following: kitchen sedegrees F, bathroom 124 degrees F, bathroom 125 degrees F, bathroom 126 degrees F, bathroom 127 degrees F, bathroom 128 degrees F, bathroom 129 degree	ne Director of Residential 0/1/11 at 2:12 PM. The DRS gative report should have e action taken. The DRS action should have been taken er admission, the am must perform accurate eassessments as needed to eliminary evaluation	W0210	W 210 Christole is committed to accurate assessments or reassessments as needed Improvement Director (trevise the Functional As include "Does the indivithe ability to regulate an and cold water temperate QID will train PD's, QD s, and ACLM's on the reby September 30, 2011. will complete the revised the assessment on each in needed. A copy of the refunctional Assessment a signature sheet will be a the Central Office.	. The Quality QID) will sessment to dual show d mix hot ure?" The DP's, CLM' evised form The QDDP d section of individual as evised und training	09/30/2011

004000

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G715	B. WING		09/02/2011	
				ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIE	R		RK LANE		
CHRIST	OLE INC		l l	ILLE, IN47448		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	temperatures. At 2 temperatures in the room. The sink wa	tubs when testing the water :59 PM, AS #1 retested the bathroom near the laundry is 124 degrees F and the shower				
	was 120 degrees F.					
	was conducted on 9 dated 3/8/10, did no	A's Functional Assessment (FA) 0/2/11 at 10:57 AM. The FA, ot assess whether or not client A te water temperature.				
	at 10:58 AM. The	B's FA was conducted on 9/2/11 FA, dated 3/8/10, did not assess at B could safely regulate water				
	at 10:59 AM. The	C's FA was conducted on 9/2/11 FA, dated 5/17/11, did not not client C could safely regulate				
	at 11:00 AM. The	D's FA was conducted on 9/2/11 FA, dated 2/7/11, did not assess nt D could safely regulate water				
	at 11:01 AM. The	E's FA was conducted on 9/2/11 FA, dated 5/19/11, did not not client E could safely regulate				
	at 11:02 AM. The	F's FA was conducted on 9/2/11 FA, dated 2/14/11, did not not client F could safely regulate				
	was conducted on 9 indicated he was ur	Administrative staff (AS) #1 9/2/11 at 9:47 AM. AS #1 nsure if the clients were able to r water temperatures.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		15G715	B. WING	1110		09/02/2	011
				STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CHRISTO	OLE INC		523 PARK LANE NASHVILLE, IN47448				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
An interview with the Director of Residential Services (DRS) was conducted on 9/2/11 at 12:01 PM. The DRS indicated the clients should be							
		oility to safely regulare water					
	temperatures.						
	1.1-3-7(a)						
W0249	` '	erdisciplinary team has	1	ł			
W 0249		t's individual program plan,					
		eceive a continuous active					
		n consisting of needed					
		services in sufficient					
		ency to support the					
		e objectives identified in the					
	individual program	on, interview and record review	11/02	.40	W 249		00/20/2011
		the sample (C), the facility	W02	249	Christole is committed to ensuri	nσ	09/30/2011
		program plan for the use of a			appropriate implementation of	115	
	snack box was imple				programs.		
	r				Christole will implement a proc	ess to	
	Findings include:				assess knowledge on Individual		
					program plans. This process wil	l be	
		conducted at the group home			completed on a monthly basis b	-	
		PM to 4:01 PM. At 2:41 PM,		- 1	QDDP to ensure that the written		
		was observed sitting on the			plans are being followed as writ		
		e box contained 2 packages of			The Quality Improvement Direct		
		raisins, 2 fruit and grain bars			(QID) will train all QDDP's on		
		C returned home from school 5 PM, client C got a package of			guidelines of the written process This training will be completed		
	crackers from her sr				September 30, 2011. The QDD	-	
	CIACKCIS HUIH HEI SI	IGEN UUA.			will inform the Parklane group l		
	An interview with Γ	Direct Care Staff (DCS) #2 was			staff about the guidelines of the		
		at 2:41 PM. DCS #2			written process by September 30		
		ould eat whatever she wanted		- 1	2011. The QDDP will submit		
	from her snack box;	he indicated there was no			monthly verification of relevant		
	limit.				training for staff participation or		
					individual's written plans. Copie		
		"s Snack Box Procedure, dated			both training signature sheets w	ill be	
		eted on 9/1/11 at 2:55 PM.			available at the Central office.		
	The procedure indic	ated the following: "2. On					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G715	B. WING		09/02/2011	
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .		ARK LANE		
CHRISTO	OLE INC			JILLE, IN47448		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, and the second se	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		has school she will select, with				
		w calorie snacks for her snack				
	box"					
		he Director of Residential				
		s conducted on 9/2/11 at 12:01				
		cated the staff should				
	implement client C's	s snack box protocol as written.				
	This deficiency was o	sited on 7/11/11. The facility				
		systemic plan of correction to				
	prevent recurrence.					
	1.1-3-4(a)					
W0426	The facility must, in areas of the facility where					
	clients who have not been trained to regulate					
	water temperature are exposed to hot water,					
	ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.					
		on, record review and interview	11/0/10/	W 426	00/20/2011	
		ing in the group home (A, B,	W0426	Christole is committed to ensur	ing 09/30/2011	
		facility failed to ensure the		that all environmental guideline	- 1	
		id not exceed 110 degrees		met. Christole conducts monthl	I	
	Fahrenheit (F).	nd not exceed 110 degrees		environmental checks including	- I	
	rumennen (r).			water temperature. In the	,	
	Findings include:			absence/change in the CLM		
				management in the group home	the	
	On 9/1/11 at 2:58 Pl	M, a review of the facility's		Program Director (PD) will con	· I	
	Maintenance/Repair	Request Forms was		the monthly checks and ensure	·	
	conducted. A form,	dated 9/1/11, indicated the		monthly documentation is comp	I	
	following: kitchen s	ink temperature was 112		until the CLM position is filled	to	
	degrees F, bathroom	n sink by laundry room was		ensure appropriate environment	ial	
		room #2 was 114 degrees F		safety.		
	,	at was tested), and bathroom				
	#2 was 115 degrees	F (did not indicate what was				
	tested).					
		conducted at the group home				
		PM to 4:01 PM. At 2:58 PM,				
		f (AS) #1 indicated he had not				
	tested the showers/t	ubs when testing the water			1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		15G715	B. WING		09/02/2	011
		<u> </u>		T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹	523 P	ARK LANE		
CHRISTO	DLE INC			IVILLE, IN47448		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	temperatures. At 2:59 PM, AS #1 retested the					
	temperatures in the bathroom near the laundry room. The sink was 124 degrees F and the shower					
	was 120 degrees F.					
	A review of client A	A's Functional Assessment (FA)				
		/2/11 at 10:57 AM. The FA,				
	dated 3/8/10, did no	ot assess whether or not client A				
	could safely regulat	e water temperature.				
		N. E				
		B's FA was conducted on 9/2/11				
	at 10:58 AM. The FA, dated 3/8/10, did not assess whether or not client B could safely regulate water					
	temperature.	it B could safety regulate water				
	temperature.					
	A review of client (C's FA was conducted on 9/2/11				
	at 10:59 AM. The	FA, dated 5/17/11, did not				
	assess whether or n	ot client C could safely regulate				
	water temperature.					
	A raviasy of client I	D's FA was conducted on 9/2/11				
		FA, dated 2/7/11, did not assess				
		nt D could safely regulate water				
	temperature.	n B could safely regulate water				
		E's FA was conducted on 9/2/11				
		FA, dated 5/19/11, did not				
		ot client E could safely regulate				
	water temperature.					
	A review of client F	s's FA was conducted on 9/2/11				
		FA, dated 2/14/11, did not				
		ot client F could safely regulate				
	water temperature.	J				
		Administrative staff (AS) #1				
		7/2/11 at 9:47 AM. AS #1				
		sure if the clients were able to				
	safely regulate their	water temperatures.				
			1	1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey pleted /2011
NAME OF I	PROVIDER OR SUPPLIEF	2	523 PA	ADDRESS, CITY, STATE, ZIF RK LANE /ILLE, IN47448	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
	Services (DRS) was	he Director of Residential s conducted on 9/2/11 at 12:01 cated the water should be es.				